

Breaking Down Barriers: Connecticut's Collaborative Re-Entry Model for Mentally Ill Offenders

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CT Criminal Justice Cross-Training Conference

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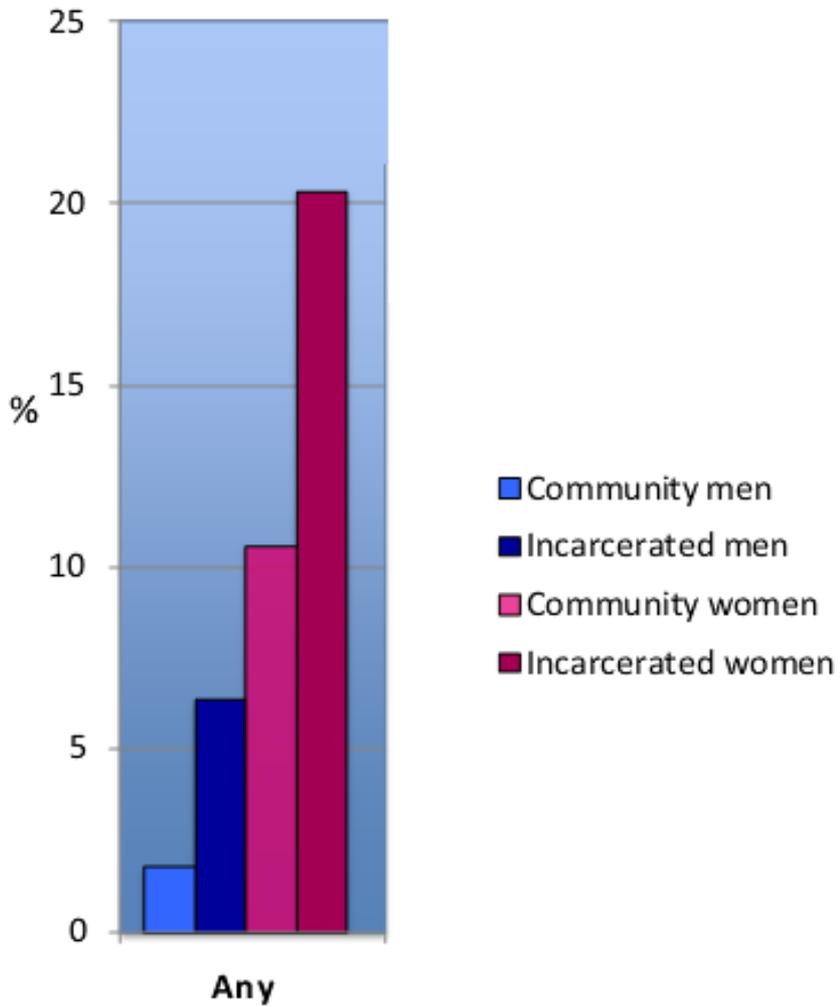
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People with serious mental illness are overrepresented in U.S. criminal justice system



Prevalence of the Mentally Ill in the CT Department of Correction

DOC population as of August 19, 2010: 18545

Total MH 3 & 4 - 3329 (18 %)

MH 3 Total 2862 (15%) – outpatient

2013 - Sentenced

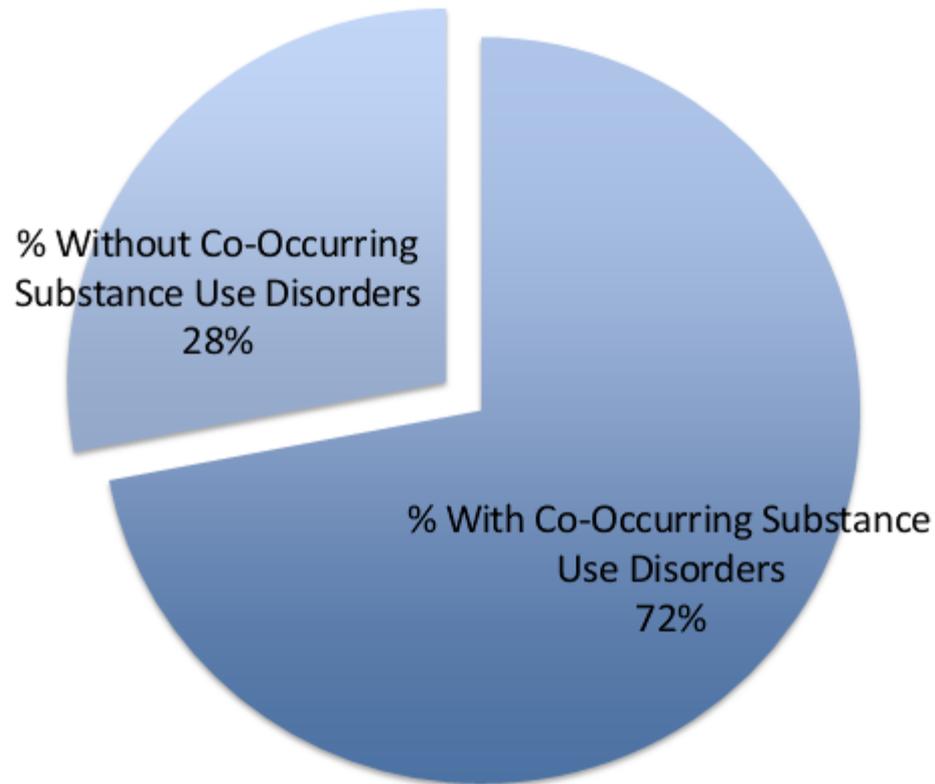
849 - Unsentenced

MH 4 Total 467 (3 %) Protective Housing

269 Sentenced

198 Unsentenced

Most have co-occurring substance abuse disorders (in CJ system)



Source: The National GAINS Center, 2004

Mental Health w/ Co-Occuring Substance Abuse and Incarceration

14% (2596) (MH 3 & 4; Substance abuse 5, 4, 3, 2)

78 % of people with mental health diagnosis also
have substance abuse issues.

*(Data received from Department of Correction on
8/19/10 date)*

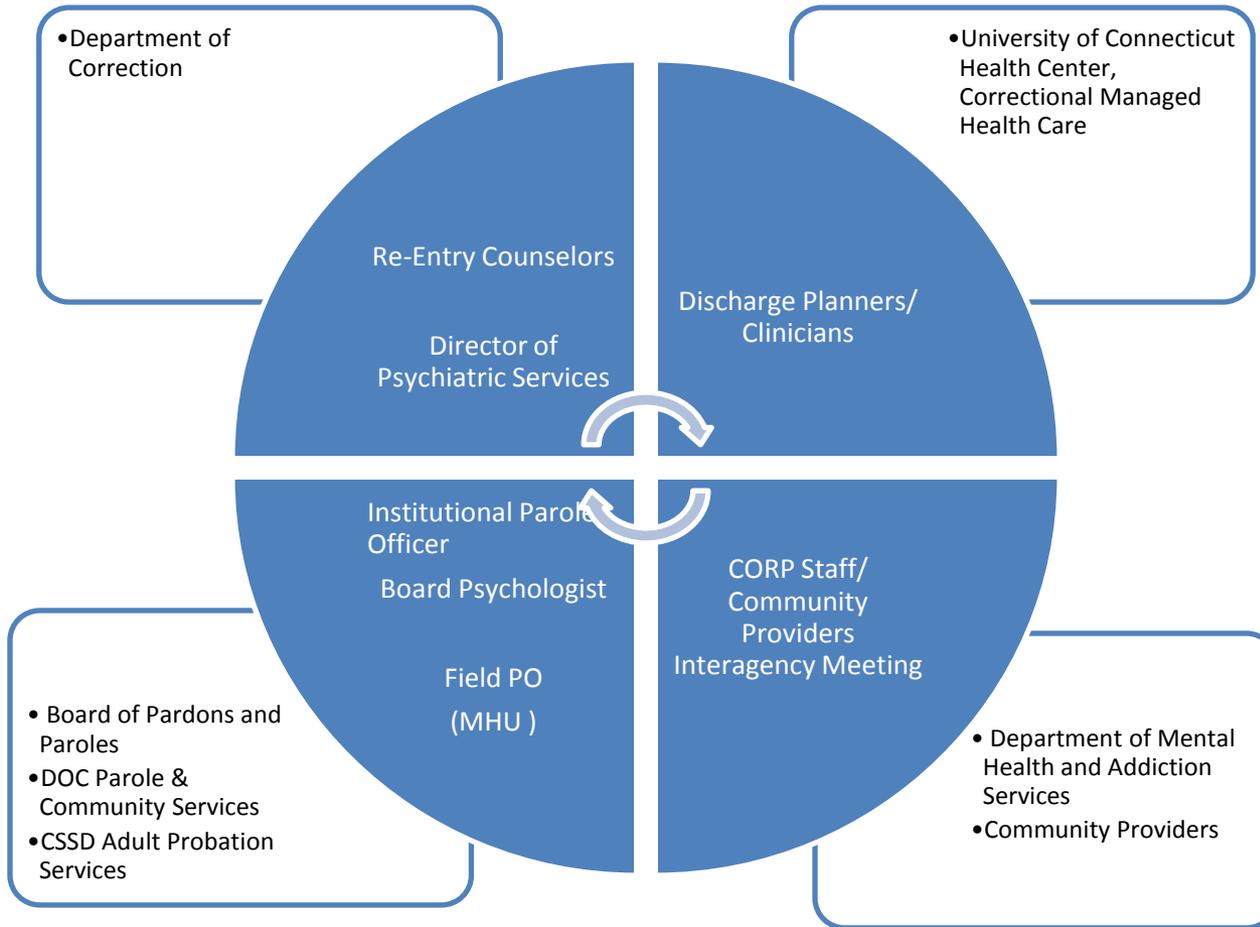
Traditional Supervision

- Large caseloads for Officers, making individualized supervision difficult
- No training for Officers supervising with Mental Health needs
- Poor communication between Officers, Mental Health staff in the facility, and mental health clinicians in the community
- offenders released with little if any connection to housing, financial, vocational, or treatment services. Problem with medications and benefits to pay for services
- Inmates with mental health needs were not identified prior to release, resulting in no specific discharge planning
- No forum to integrate services

Failure Rate on Community Supervision

- Most are supervised in the Community...and often “fail”
- 2 to 1

KEY AGENCIES and AGENTS



Integrative Programs

- DMHAS-DOC**
- Connecticut Reentry Program (CORP)
 - Interagency Referral Program

- DMHAS-CSSD**
- Supervised Diversionary Program (SDP)

- DMHAS-Law
Enforcement**
- Crisis Intervention Team (CIT)

Integrative Programs

continued

DMHAS-CSSD &DOC

- Mental Health Day Reporting Center (MHDRC-CREST)
- Jail Diversion Program (JD)
- Women's Jail Diversion Program (JDW)
- Advanced Supervision Intervention and Support Team (ASIST)
- Specialized Mental Health Parole and Probation Units

Development of CMHC Discharge Planning and Transitional Services Program: 2000 – Present

Vickie Alston, MSW, LCSW, QICSW, CDSW
Manager of Transitional Services
University of CT Health Center
Correctional Managed Health Care



Health Care Discharge Planning: *In the Beginning...2000*

- No lists or queries
- No aftercare plans
- No dedicated discharge planners
- No Medical Assistance through DSS
- No appointments
- No referrals to Department of Mental Health and Addiction Services (DMHAS)
- Often left without medications

Establishment of Transitional Services Program



- 2004: Program Manager Transitional Services
- March, 2006: **CMHC-DOC Memorandum of Agreement (MOA)**
 - Identified role of Transitional Services:
 - “DOC & CMHC shall provide a discharge planning process to facilitate continuity of care of released offenders.”
 - “UCHC shall designate a discharge planner for each functional unit...”
- August, 2007: **CMHC-DOC Strategic Plan**
 - Transitional Services identified as 1 of 7 key areas of CMHC health services delivery system

CMHC Discharge Planning Team

- 13 discharge planners
- Licensed medical and mental health staff
- Assigned to specific correctional jails and prisons
- Multidisciplinary
- Statewide Team
- Cross-Trained

CMHC Discharge Planners: Target Population

- Facility Tracking Systems to identify upcoming discharges:
 - Accused: 45 days to next court date
 - Sentenced: EOS, TS, Parole, 45 day-reentry
- *CLASSIFICATION SCORING:*
 - Mental Health & Medical 3, 4, and 5s
 - Classification Sub-codes:
 - I.e., D=DMHAS, T=TBI, R = DDS

Other Resources for Identifying Upcoming Discharges

- Health Services staff
- Offender contacts discharge planner
- DMHAS Jail Diversion Clinicians
 - Give “heads up” for MH 5s and Suicide Watch offenders attending court
- CSSD Jail Re-Interview Specialists
- Public Defender Social Workers
 - Discharge planner give “Heads Up” re: critical MH or medical information to assist in their advocacy
 - Liaison between discharge planner and Public Defender

3 Primary Activities of Discharge Planning

- **Coordination**
- **Continuity of Care**
- **Collaboration**

Coordination: Activities of Discharge Planner

- Face-to-face interviews
- Facilitate order for supply of 2 week medications & durable medical equipment/supplies
- Complete W-10 Interagency Referral Form
- Complete or coordinate Entitlement applications:
 - Department of Social Services (DSS): Pre-Release Entitlement Unit (PREU)
 - Veterans Administration
 - ABI/TBI Waiver through DSS

Continuity of Care

- Community medical and mental health appointments
- Admissions to medical and/or mental health hospital
- Nursing home placements
- Dialysis services
- Other...

DISCHARGE PLANNER = “AIR TRAFFIC CONTROLLER”



BOARD OF PARDONS AND PAROLES

David Rentler, PsyD,
Supervising Psychologist

CT Board of Pardons and Paroles

- Preliminary Dockets for offenders with mental health flags are sent to CMHC clinical staff 6 to 12 months prior to hearing.
- Clinicians complete updated mental health evaluations for the Board, including treatment participation and recommendations for community care.
- IPO from DOC's mental health facility and Board Psychologist attend Interagency Meetings. Prior to hearing, Board staff identify cases with severe mental illness who may be in need of intensive case planning. Referral is made during interagency meeting to begin discharge plan to present to Board.
- Board Psychologist consults with Panel Members about mental health diagnoses, treatment, and release stipulations.

CT Board of Pardons and Paroles

- Participate in case conferences on especially challenging and/or difficult cases, either prior to or after a hearing, especially for offenders who would benefit from a period of supervised release to facilitate transition back into the community.
- Board Psychologist may be consulted by Board Members, Institutional and Field Parole MHU staff for offenders who are pending revocation hearings. Again, focusing on treatment needs during re-incarceration and re-release plans and stipulations
- Board Psychologist works closely with CMHC on identifying potential medical and/or compassionate parole candidates and facilitating medical parole hearings.
- Board Psychologist conducts Clinical Risk Assessments for the Board for high risk and high profile cases and cases referred by the Parole Board Staff and panel members.
- Board Psychologist provides training to staff on various risk assessment and mental health issues.

Community Supervision

**Rebecca Segui, Mental Health Unit,
Adult Probation Officer
Court Support Services Division**

Some Unique Aspects of the Units

- Smaller case loads allowing for individualized attention
- Dedicated supervisor
- Extensive training of officers, both in-house and in the community

Mental Health Units

- 5 Parole Officers statewide
- 10 Probation Officers in 8 locations
 - Bridgeport
 - Hartford (2 officers)
 - Middletown
 - New Britain
 - New London
 - Norwich
 - New Haven (2 officers)
 - Waterbury

- All the officers have received specialized training from NAMI, CABLE, DMHAS, and CSSD
- Work closely with providers and natural supports
- CIT Certification

- Addressing Treatment needs
- Address criminogenic and basic needs
- Advocate
- Build a relationship/trust
- Collaborate with treatment providers
- Case Planning

- Untreated mental illness may lead to criminal behavior
- Treated mental illness along with addressing criminogenic and basic needs can lead to reduction in criminal behavior

Probation MHU Outcomes

- Research has shown that people with serious mental illness are over-represented in the CJ system.
- Offenders with SMI also have other significant needs including poverty, homelessness, unemployment, and stable mental health and/or substance abuse treatment.

- Piloted the Mental Health Case Management Project (MHCM) in March of 2007
- Project goal was to decrease recidivism with intensive supervision. This would allow for more in-depth assessments, more appropriate service referrals, and more positive contacts with clients and service providers

Evaluation Summary and Results

- Evaluation studied 710 mental health probationers from 3/2007 through 9/2008 and followed them for one year
- Created a comparison group of similar probationers who did not participate in the MHCM project
- Mental Health clients were older (70% were over 30), single (5% were married), under-educated (58% did not have a high school diploma), unemployed (only 12% had jobs), and habitually criminal (they averaged 14 arrests and only 5% were first time offenders)
- 27% of the clients were female
- Arrests were significantly reduced by the MHCM project
 - 30% of MHCM group were rearrested versus 41% of the comparison group
- There were no differences in technical violation rates
 - 10% of MHCM group versus 8% of the comparison group

Community Supervision

**Edward Kendall, Mental Health Unit,
Parole Manager
CT Parole & Community Services**

Selection of Parole Officers

- Mental Health Parole Officers were chosen based upon interest, level of experience, and interview. All applicants were currently parole officers
- To ensure only qualified and motivated officers for the mental health unit as it is a high priority for the department
- The unit's officers have a wide variety of experience and strengths. For example, two officers are clinically trained social workers with Master's Degrees, another has twenty years of experience as a correctional counselor, and another has extensive experience as a parole officer with many community contacts

Officer's Procedures

Development of a community treatment team:

Participants in the treatment team may include: Department of Mental Health and Addiction Services (DMHAS); Parole Board Psychologist; facility discharge planners; Connecticut Offender Reintegration Program (CORP) release planners; Uconn Managed Health Care discharge planners; local mental health authorities (LMHA); Network adult behavioral services (ABH) facilities; Substance abuse treatment providers, Alternative to Incarceration program providers (AIC)

Completing a Plan: After reviewing the file, meeting with the community treatment team, conducting a jail interview and performing a home investigation, the officer shall complete a detailed parole plan.

Jail Interview

Officers visit the offender at the correctional facility and conduct a jail interview to:

- assess what the offender needs to be successful in the community
- review the Board of Parole conditions with the offender
- review the mental health evaluation and recommendations
- ensure all conditions and recommendations are understood
- discuss previous non-complaint behavior with the offender
- discuss previous failure to maintain medication schedules
- discuss failures to attend treatment sessions
- discuss substance abuse issues and treatment
- discuss living arrangements and expectations while on supervision
- review insurance (SAGA) and Social Security Disability, and employment

Home Investigation

- Location of address and persons living at residence
- Possible factors which may have contributed to past failures in community
- Possible requirements of electronic monitoring program (EMP) or global positioning system (GPS)
- How offender can utilize community mass transportation, their access to treatment facilities
- Identify family support system
- Meet with the offender's support group to explain conditions of release and gain assistance with the treatment plan
- Determine if residence is suitable for the offender and the community is safe

Field Supervision of Offenders

- Mental Health and Substance Abuse Treatment, including Alternative to Incarceration Program
- Appropriate Housing
- Assistance obtaining Social Services and Vocational Training
- Medication Compliance and Sobriety
- Home and Employment Visits
- Contact with Law Enforcement
- Work in conjunction with Probation

The Development of the Clinical Plan

Suzanne Ducate, M.D.

Director of Psychiatric Services,
Connecticut Department of Correction

Forensic Psychiatrist Role in Case Management

- Conduct case conferences routinely and in response to urgent requests to assess high-risk patients, behavior management concerns, and diagnostic clarification
- Unlimited availability for consultation and supervision
- Provide daily telephone coverage and emergency response
- Assist in identifying appropriate patients for the officer's caseloads

Training of Parole Officers

- Both Initial Training at the Inception of the Program and Ongoing Training is conducted by the Department Forensic Psychiatrist
- Topics Presented Include:
 - The Mental Status Examination
 - The Detection of Malingered Mental Illness
 - Antipsychotic Medication
 - Psychotic, Mood, Anxiety, and Adjustment Disorders
 - The Impulsive Patient
 - Most Commonly Prescribed Medications
 - Interview Techniques

Criteria for Inclusion of Offender on Mental Health Unit Caseload

- Offender is identified Department of Mental Health and Addiction Services (DMHAS) client or for youths is identified Department of Children and Families (DCF) client with mental health needs
- Offender in Connecticut Offender Reintegration Program
- Offender meets DMHAS criteria for their target population
- DSM-IV Axis I diagnosis of schizophrenia, schizoaffective disorder, psychotic disorder, bipolar disorder, or post traumatic stress disorder. For youths only include a diagnosis of long-standing attention deficit disorder
- History of serious suicide attempts
- Currently prescribed more than one psychotropic medication or prescribed an antipsychotic medication
- History of more than one psychiatric hospitalization

Temporary Correctional Infirmary Placement

- Offenders can be returned to a correctional facility to address relapse or medication noncompliance for short term care and stabilization
- Facility based infirmary care is supervised by the Unit's psychiatrist
- Officers meet with the facility treatment team to develop a new release plan
- Officers work with the Board of Parole to return the offender to the community as quickly as possible
- Offenders may also be treated in Community Hospitals under the supervision of the Officer

Measures of Success

- Mental Health Unit Offenders have a lower rate of return to incarceration than standard Parole Division caseloads.
- Acting quickly upon technical violations, and judicious use of hospitalization prevents criminal recidivism.
- Expanding collaboration with the Board of Pardons and Paroles.

DMHAS Forensic Services

Erin Leavitt-Smith, LPC,

Transition Services Manager

Department of Mental Health & Addiction

FORUM FOR COLLABORATION

Monthly Interagency Meetings

- Under the direction and leadership of the DMHAS Transition Services Manager – meetings held centrally at DMHAS CVH in Middletown, CT
- Shared Mission, Vision, and Goals :
 - Effective transition and case management for mentally ill offenders
 - Re-entry is a seamless continuum of care
 - Reduce recidivism, improve continuity of care, and reduce cycling of mentally ill offenders through the systems

FORUM FOR COLLABORATION

Monthly Interagency Meetings

- Representatives from each agency attend the monthly meetings to discuss, plan, refer, and coordinate services for cases (Multidisciplinary)
- Any agency can initiate case referrals / discussions and planning for continuity of mental health care and services, including basic needs, such as housing and financial assistance.
- At any stage of the criminal justice process (Pre-trial, Pre-Parole, Supervised Release Revocations or Violators, etc.)

Interagency Meeting

Goals and Mission

- Discuss status of core MH programs and initiatives (e.g., CORP, ASSIST, Mental Health Unit Parole and Probation).
- Identify and coordinate release plans and services for inmates who will be releasing from prison (EOS, Parole, Probation, Parole to Probation)
- Communicate information about the status and needs of the offenders.
- Problem-solve challenges presented by difficult cases (e.g., offender who self-sabotages just prior to each parole release date; sex offender with mental health issues who will be homeless upon release)

Department of Mental Health and Addiction Services (DMHAS)

- Offenders are referred to Local Mental Health Authorities 3-6 months prior to release; referral is generated by CMHC Discharge planners, mental health clinicians in the facilities.
- A representative from the Local Mental Health Authority visits / assesses the inmate prior to release;
- An appropriate discharge plan is developed,
- The case is followed by DOC/DMHAS Liaison to ensure services are secured.

CT Offender Re-entry Program (CORP)

COLLABORATIONS: DMHAS, DOC, CSSD, Parole, Labor, Workforce Investment Board, Families in Crisis, Community Partners in Action, and Faith Based Organizations.

- **PURPOSE:** CORP provides services (Voluntary) for offenders with significant mental illness, returning to the Hartford, Bridgeport, or New Haven communities after an extended period of incarceration
- **GOAL:** Emphasis is on reducing recidivism by identifying and intervening in those areas most in need (**Dynamic Risk Factors**)
- **SERVICES:** The CORP program extends culturally appropriate intensive case management, integrated mental health and substance abuse treatment services, and linkages for men and women to their community
- **CONTINUITY OF CARE:** Communication is maintained with the facility mental health staff, Parole / Probation Officer, and private / state community service providers
- **PROCESS:** Prior to discharge from DOC, mental health clinicians provide comprehensive pre-release assessment and skills building program (In-Reach) including the development of a community support network. After discharge, continuing services are provided through the Local Mental Health Authorities in those communities
- **PROGRAM EVALUATION:** CORP significantly reduces recidivism for arrest among participants

Case Study – “Shelly”

- Demonstrates the collaborative process by state agencies to expedite discharge planning for an offender as a result of:
 - Coordinated effort by Reentry Team
 - Expedited access to entitlements
 - COMMUNICATION...
TEAMING...CLEAR
ROLES



“Shelly”

- Demographics
 - 49 year old, Caucasian woman
 - Incarcerated 1997 - 14 year sentence
 - Sex Offense - Risk of injury
 - Classification scores:
 - Medical – 3; MH - 4
 - Overall risk score – 3
 - 44 Disciplinary tickets



“Shelly”

- Female Sex Offender approved for parole for over two years but not yet released.
 - Long incarceration; no “normal” community life experience
 - Low risk for sex offense recidivism
 - Repeated disciplinary problems due to anxiety about impending release
 - Multiple and complex clinical needs due to Axis II pathology
 - Case conference to link correctional with community services

“Shelly”

- Solutions to inability to release to community:
 - Preparation by Correctional facility mental health program to provide needed coping skills
 - Liaison with Parole Board Psychologist to modify stipulations to accommodate mental health needs
 - Assignment to the Mental Health Parole Unit to ensure needs are met and inmate had optimal opportunity for success
 - Meaningful connection with community providers over many months to prepare for release
 - Close supervision by trained parole officer